APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

For Physicians and Allied Health Professionals

Limits of Liability: $500,000 Per Medical Incident/$1,500,000 Annual Aggregate

INSTRUCTIONS: Please complete all sections of this form in ink. All sections requiring a signature or initials must be signed in ink.

______ Signed, dated and fully completed application.
______ Curriculum vitae.
______ Copy of the **Declarations Page** from your current malpractice insurance carrier's policy.
______ Copy of your current license to practice medicine in Pennsylvania.
______ Copy of your current DEA registration.
______ "Policy History Reports", "Claim History Reports", or "Loss Runs" covering the past ten years. These may be obtained from your current or prior carrier(s).
______ A copy of your letterhead.
______ A copy of any advertisements for your services.

This is an application for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that (a) arise from incidents or events that happen while the policy is in force and that involve your professional services or the use of your professional office premises, and (b) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval. No coverage exists until a binder or Declarations Page, together with any endorsements that may apply, has been issued to the named insured.

Send completed application with associated documentation to:

William Knox
The HDH Group, Inc.
U.S. Steel Tower, Suite 1100
600 Grant Street
Pittsburgh, PA 15219

PLACE INDIVIDUAL'S NAME HERE:

____

If you have any questions regarding the application process or any information contained in this packet, please contact William Knox at (412) 391-7300, extension 1179 or email at wknox@hdhgroup.com

The policy for which you are applying will be issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations or your state. State insurance guarantee funds are not available for your risk retention group.

NEPRRG
Northeast Physicians Risk Retention Group, Inc.

PERSONAL INFORMATION

First Name	MI	Last Name	Suffix

Degree or Title	Social Security Number	Date of Birth	Office Phone

Primary Office Address	Office Fax

City	State	Zip Code	E-mail Address
	PA		

Any other name by which you have been known	Website Address

LICENSURE AND CERTIFICATION

Please indicate in which states you were EVER licensed to practice medicine:

State	License Number	Date of License	Current (Yes/No)
Pennsylvania			

Please indicate all board certifications (by a member-board of the American Board of Medical Specialties or Osteopathic Specialties)

Specialty Board	Status (Certified/Eligible)	Certificate Number	Original Certification Date	Expiration Date

PRACTICE INFORMATION

Are you applying for coverage as a: / If Primary care, please mark which specialty:

	Coverage type					
	Primary Care Physician →		Family Practice		Internal Medicine	
			General Practice		Pediatrics	
	Specialist (Please specify) →					
	Non-physician Practitioner (Please specify) →					
If you have one or more sub-specialties, please identify →						

First Date of Practice	Enter exact date of start of practice:
Please indicate your first date of practice **IF** you completed a medical residency or fellowship program within the past three years of the date of inception of coverage for which you are applying **and** you are in practice for the first time since completion of that program:	

Applicant's Signature (All pages must be signed)   Date

Procedures and practices: (Check the box if applicable during any part of the coverage period, including any retroactive period, if applicable.)

	No surgery (see last page for definition)		Normal obstetrical deliveries
	Minor surgery (see last page for definition)		Supervision on nurse midwives
	Major surgery (see last page for definition)		Left heart catheterization
	Assist in major surgery on your own patients		Right heart catheterization
	Assist in major surgery in patients other than your own		Interventional radiology
	Administration of general, caudal or spinal anesthesia		Caesarian sections
	Deep radiation/X-ray therapy (over 120 kv)		Abortions
	Intestinal surgery for obesity		Endoscopic procedures other than sigmoidoscopy
	Laser surgery		Prenatal care: up to _____ weeks
	Colon-rectal surgery: _____% of surgical practice		Remote services (internet or telemedicine)

Practice Organization:

Check which type of practice applies:		**Average workload/volume per week**	
	Solo Unincorporated	8 hours or less	
	Solo professional corporation	16 hours or less	
	Member of limited liability company	24 hours or less	
	Member of a professional association	More than 24 hours per week	
	Shareholder or employee in a professional corporation	Patient visits per week	
	Employee or contractor for a professional corporation, hospital, clinic, etc.	Major surgeries per week	
	Other:	Obstetrical deliveries per week	

PENNSYLVANIA MEDICAL SOCIETY MEMBERSHIP:					
Are you a current member?	Yes	No	Pending	If **YES** or **Pending**, County Affiliate:	

Corporate Coverage:

Do you wish coverage for your Professional Corporation or Partnership?	Yes	No
If yes, ONE separate corporation/partnership application is required for each entity.		
If no, is the corporation/partnership insured elsewhere?	Yes	No

Current Office Locations: List all current office or clinic practice locations in this section. Include all locations whether or not NEPRRG insurance is desired at that location. If additional space is required to show more than four practice locations, please attach a separate sheet or your brochure.

Name of Location	City and State	County	% of practice

List Associates: (If more space is required, attach roster)

Associate	Specialty	If non-affiliated physicians are utilized to cover your practice, please describe those arrangements including the name(s) of the practitioner utilized.

Applicant's Signature (All pages must be signed) __________ Date __________

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WORK HISTORY

Starting with your current practice, list all employment since completion of post-graduate training:

Name of Location	City and State	From (Date)	To (Date)

HOSPITAL PRIVILEGES

Please provide the following information on your CURRENT hospital privileges:

	Hospital Name	City, State	Type of privileges	Specialty or department
1				
2				
3				
4				

INSURANCE HISTORY

You must attach the declarations page from your current policy	Current Policy	First Prior Policy	Second Prior Policy
Insurance Carrier			
Type of policy (Claims-made or Occurrence)			
Effective Date			
Expiration Date			
Retroactive date (Claims-made only)			

If your current policy is a "Claims-Made" policy, you MUST either purchase prior acts coverage from your new carrier OR obtain a reporting endorsement from your current carrier.

If you DO NOT WANT or DO NOT NEED prior acts coverage, please indicate this decision by signing in the space provided. By signing, you are acknowledging that your retroactive date of coverage WILL BE THE SAME as your effective date of coverage.	**I decline or don't need retroactive coverage**: Applicant Signature

Applicant's Signature (All pages must be signed) Date

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ADDITIONAL UNDERWRITING INFORMATION

Please answer the following questions. YES responses REQUIRE additional explanation in the area provided. If additional space is needed, please use the area provided on the last page of this application.

Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?		
Medical or professional license	Yes	No
DEA or CDS/BNDD registration	Yes	No
Hospital medical staff membership	Yes	No
Clinical privileges or other rights on any hospital medical staff	Yes	No
Employment by any hospital, institution or the military	Yes	No
Professional society memberships	Yes	No
Participation in any private, federal or state health program (i.e., Medicare, Medicaid)	Yes	No
Participation in an HMO, PPO or other managed care organization	Yes	No
Board certification	Yes	No

RATING INFORMATION				
Do you serve in a hospital emergency room for which you require NEPRRG coverage?			Yes	No
If **YES**, number of hours per week:	____ 8 hours or fewer per week		____ Greater than 8 hours per week	
Do you serve in a prison environment for which you require NEPRRG coverage?			Yes	No
If **YES**, number of hours per week:	____ 8 hours or fewer per week		____ Greater than 8 hours per week	
If you are a GENERAL SURGEON, do you perform:	Obstetrical Surgery?	Yes	No	______% of total surgery
	Orthopedic Surgery?	Yes	No	______% of total surgery

At any time, have you ever been:		
Convicted of a criminal offense?	Yes	No
Convicted of a felony?	Yes	No
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of a trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country?	Yes	No

Have you ever at any time or are you currently:		
Under indictment for any crime?	Yes	No
The subject of an investigation by any private, federal, state or health insurance program or state licensing board?	Yes	No
Under investigation by any state licensing board or federal agency?	Yes	No
The subject of any adverse action reports to a state or federal databank?	Yes	No

Have you either voluntarily or involuntarily:		
Withdrawn your application for medical staff membership at any facility?	Yes	No
Withdrawn your request for any clinical privileges at any facility?	Yes	No

Health Status:		
Are you able to perform the professional duties of the position with or without reasonable accommodation? (A "Yes" answer to this question does not require additional documentation.)	Yes	No
Are you currently using illegal substances or illegally using substances?	Yes	No

____ ____________________
Applicant's Signature (All pages must be signed) Date

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PROFESSIONAL LIABILITY HISTORY

Question		
Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer?	Yes	No
Has any claim or suit for alleged malpractice been brought against you in the past ten years?	Yes	No
Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?	Yes	No

IF YOU ANSWER YES TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING SECTION:

CASE 1

Date of occurrence of event		Date case was filed		Plaintiff's Name		Carrier involved	
Your status in this case				Status of case			
	Primary defendant				Pending		Dismissed/dropped
	Co-defendant				Found for plaintiff		Settled. If settled, state amount:
					Found for defendant	Amount:	
Alleged harm to patient:							
Circumstance of patient's illness:							
Any other pertinent details:							

CASE 2

Date of occurrence of event		Date case was filed		Plaintiff's Name		Carrier involved	
Your status in this case				Status of case			
	Primary defendant				Pending		Dismissed/dropped
	Co-defendant				Found for plaintiff		Settled. If settled, state amount:
					Found for defendant	Amount:	
Alleged harm to patient:							
Circumstance of patient's illness:							
Any other pertinent details:							

Applicant's Signature (All pages must be signed) ______________________ Date ____________

CASE 3

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case		Status of case			
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled. If settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

CASE 4

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case		Status of case			
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled. If settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

CASE 5

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case		Status of case			
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled. If settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

Applicant's Signature (All pages must be signed)   Date

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CASE 6	Date of occurrence of event	Date case was filed		Plaintiff's Name		Carrier involved
	Your status in this case			Status of case		
		Primary defendant		Pending		Dismissed/dropped
		Co-defendant		Found for plaintiff		Settled. If settled, state amount:
				Found for defendant	Amount:	
	Alleged harm to patient:					
	Circumstance of patient's illness:					
	Any other pertinent details:					

DEFINITIONS:

MAJOR SURGERY: Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis; any other operation which, because of the condition of the patient, or the length or circumstances of the operation, presents a distinct hazard to life. It also includes but is not limited to: removal of tumors, open bone fractures, amputations, the removal of any gland or organ, plastic surgery, and any other operation performed under general anesthesia.

MINOR SURGERY: Any operation not defined as major surgery.

NO SURGERY: The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia), and do not ordinarily assist in surgical procedures.

The undersigned agrees to fully comply with the conditions of membership in NEPRRG and understands that noncompliance may result in a non-renewal of coverage. The undersigned declares that, to the best of his or her knowledge and belief, that the statements set forth herein are true. Although the signing of this application does not bind the undersigned on behalf of the applicant or its organization or other insured person to effect insurance, the undersigned agrees that this application and its attachments shall be the basis of the contract should a policy be issued and shall be attached to, and form part of, this policy. The Company is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary.

Notice to Pennsylvania Applicants: Any person, who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and subjects such a person to criminal and civil penalties.

____________________________ Applicant Signature

________________ Date

The policy for which you are applying will be issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance guarantee funds are not available for your risk retention group.

ADDITIONAL SPACE FOR ANSWERS TO QUESTIONS